Sample Clinical Psychology Internship Report 111

masters in psychology (Indira Gandhi National Open University)

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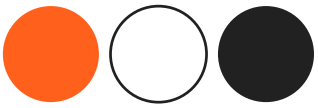

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ACKNOWLEDGEMENT

With grateful heart I would like to remember the persons who have helped me during the course of my internship program. I wish to place on record my words of gratitude to_____, Consultant Psychiatrist and head of the department of psychiatry for his guidance and support.

I am thankful to _____(clinical psychologist), _____ (Clinical psychologist) and _____ (Counselor and Art Therapist) for providing their valuable guidance at all stages of the study, their advice, constructive suggestions, positive and supportive attitude and continuous encouragement.

I owe my wholehearted thanks and appreciation to the entire staff of the _____ for their cooperation and assistance during the course of my internship.

I hope that I can build upon the experience and knowledge that I have gained and make a valuable contribution towards this industry in coming future.
Thank you to all my teachers in IGNOU study center, for their direction and support.

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INTRODUCTION

An internship is a trained and supervised experience in a professional setting in which the student is learning and gaining essential experience and expertise. Internship is meant for introducing candidates either full-time or part-time to a real world experience related to their career goals and interests. It may, but does not have to be related connected to one's academic major or minor. Internships can be done during the academic semester and or summer depending upon the spaced out curriculum. There are several varieties of internship: some are paid some are not and some offer credit towards graduation.

Internship is an excellent way to build those all important connections that are invaluable in developing and maintaining a strong professional network for the future. Internships provide real world experience to those looking to explore or gain the relevant knowledge and skill required to enter into a particular career field. Internship is relatively short term in nature with the primary focus on getting some on the job training and taking what's learning in the classroom and applying it to the real world. Interns generally have a supervisor who assigns specific tasks and evaluates their overall work. For internship for credit, usually a faculty sponsor will work along with the site supervisor to ensure that the necessary learning is taking place. Internship can be done by high school or college students to gain relevant experience in a particular career field as well as to get exposure to determine if they have a genuine interest in the field.

An internship is a way to determine if the industry and the profession is the best career option to pursue. Interns not gain practical work experience in a field that students intend to pursue but also build experience in local, national and international platforms.

It also assists students in making informed career decisions. Through daily activities and interpersonal interactions, interns are able to gather valuable information about their field. They also get a chance to evaluate their own strengths and preferences before they formally enter the job market. Such information can be helpful in deciding if they have made the right career choice and can reinforce doubts or resolves relating to their career goals.

Internships may present a potential for an offer of full time employment. Professional work experience is the most beneficial advantage that can be acquired by completing an internship for students or fresh graduates, having this work experience on their resume can be the

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best way to get the foot in the door. This can result in more job offers as compared to individuals who lack such work experience.

OBJECTIVES OF INTERNSHIP

The main objective of the internship course is to facilitate reflection on experiences obtained in the internship and to enhance understanding of academic material by application in the internship setting. Internships will provide students the opportunity to test their interest in a particular career before permanent commitments are made. Apart from it is more important because:

1. Internship students will develop employment records or reference that will enhance employment opportunities.
2. Internship will provide students the opportunity to develop attitudes conducive to effective interpersonal relationship.
3. Internship will provide students with an in-depth knowledge of the formal functional activities of a participating organization.
4. Internship programs will enhance advancement possibilities of graduates.
5. Internship will help the trainees to develop skills and techniques directly applicable to their careers.
6. Internship will provide students the opportunity to develop attitudes conducive to effective interpersonal relationships.

PURPOSE OF INTERSHIP IN PSYCHOLOGY

1. To develop facility with a range of diagnostic skills, including: interviews, case history-taking, risk assessment, child protective issues, diagnostic formulation, triage, disposition, and referral.
2. To develop further skills in psychological intervention, including: environmental interventions, crisis intervention, short-term, goal-oriented individual, group, and family psychotherapy, exposure to long-term individual psychotherapy, behavioral medicine technique, and exposure to psychopharmacology, case management, and advocacy.
3. To develop facility with a range of assessment techniques, including: developmental testing (elective), cognitive testing, achievement testing, assessment of behavior, emotional functioning, assessment of parent-child relationship and family systems, and neuropsychological evaluation

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(elective). Assessment training across will include both current functioning and changes in functioning.

4. To develop facility with psychological consultation, through individual cases and participation in multidisciplinary teams, including consultation to: parents, mental health staff (e.g., psychiatrists, social workers) medical staff (e.g., physicians, nurses, PT, OT, etc.), school systems, and the legal system. Consultation training occurs in both the inpatient and outpatient setting, both downtown and in the suburbs, and ranges.

5. To learn the clinical, legal, and ethical involved in documentation of mental health services within a medical setting.

6. To learn to promote the integration of science and practice, related to theories and practice of assessment, intervention, and consultation. Interns are trained in empirically-supported treatments (e.g., parent training groups, inpatient treatment protocols for school avoidance, eating disorders), and behavioral medicine protocols (e.g., medical noncompliance, pain management, headache treatment, toilet training).

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PROFILE OF THE ORGANIZATION / INSTITUTION

Profile of the Doctor

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PSYCHOPATHALOGY

Psychopathology is the scientific study of mental disorders, including efforts to understand their genetic, biological, psychological, and social causes; effective classification schemes (nosology); course across all stages of development; manifestations; and treatment. The term may also refer to the manifestation of behaviors that indicate the presence of a mental disorder.

The word *psychopathology* has a Greek origin: 'psyche' means "soul", 'pathos' is defined as "suffering", and 'logos' is "the study of". Wholly, psychopathology is defined as the origin of mental disorders, how they develop, and the symptoms they might produce in a person.

Patients with mental disorders are normally treated by psychiatrists, or psychologists, who both specialize in mental health and diagnose and treat patients through medication or psychotherapy. These professionals systematically diagnose individuals with mental disorders using specific diagnostic criteria and symptomatology found within the *Diagnostic and Statistical Manual of Mental Disorders* or ICD.

PSYCHODIAGNOSIS

It is a a branch of psychology concerned with the use of tests in the evaluation of personality and the determination of factors underlying human behavior.

What is the difference between a psychodiagnostic assessment and a psychiatric consultation?

A psychiatric consultation consists of a thorough clinical interview, review of records, and observation of the patient's behavior by a psychiatrist or psychologist. For many psychiatric concerns, this is the most appropriate referral and connects the patient with a mental health provider. Psychodiagnostic testing is a specialized diagnostic procedure that identifies and quantifies degrees of psychopathology. In contrast to a psychiatric consultation, it uses written, oral and projective instruments to evaluate a patient's mental processes and to assess how their thinking and emotions are likely to impact their behavior. Therefore, psychodiagnostic testing

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provides objective data on a patient's psychological functioning and is a useful tool for clarifying confusing clinical presentations.

How would psychodiagnostic testing help patients?

Psychodiagnostic testing enhances diagnostic accuracy by controlling for subjective opinion because it uses highly reliable, standardized tests that have been validated in clinical trials. For example: the reliability of the Wechsler Adult Intelligence Scale, which measures cognitive abilities and determines intelligence quotients, ranges from impressive .93 to .97. Because it is able to provide both accurate diagnostics and to grade the severity of impairment, psychodiagnostic testing helps the physician or psychiatrist to make pharmacological or psychotherapeutic treatment recommendations that have the highest likelihood of success. "Differential therapeutics", the prescription of effective treatments and proscription of ineffective ones, is the standard of care in contemporary medicine. Psychodiagnostic testing, because of its standardized and objective qualities, aids the practitioner in developing differential treatment recommendations.

When to consider referring a patient for psychodiagnostic testing?

Patients sometimes present confusing clinical pictures. They require sophisticated and extensive work-ups to distinguish the psychological contributions that confound accurate diagnoses and/or treatment of their conditions. Referral for psychodiagnostic testing is a cost-effective and valuable tool in the diagnostic decision-tree.

Examples of appropriate referrals for psychological testing include:

- Patients whom you suspect have substance abuse problems
- Patients with possible learning disabilities
- Patients with suspected mental retardation or poor intellectual functioning
- Patients with mood disorders
- Patients with anxiety and panic disorders
- Patients who have experienced trauma
- Children and adolescents who are "acting-out"

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- Patients with suspected personality disorders

What will the report indicate? How will this affect treatment?

The psychodiagnostic report is designed to answer specific referral questions. These may include questions regarding diagnostic clarification, differentiation between transient "state" disorders and long-standing "trait" disorders (DSM Axis I versus Axis II disorders), intellectual functioning, learning style, current psychosocial stressors, and adaptive ability. Reports also include treatment recommendations that are based on the synthesized results of the clinical interview, mental status exam, patient's personal, family and cultural history, and findings from the standardized tests. Clinicians can use these objective recommendations to develop interventions with the highest likelihood of success

What other professions rely on psychological testing?

Psychodiagnostic testing is a widely recognized diagnostic procedure that is used in a variety of non-medical settings. Examples include:

- **Forensics**: In this context, 80% of psychological testing is ordered when the defendant's psychiatric condition is seen important in a criminal case. Other legal uses of psychodiagnostic testing include child custody evaluations, contested estates, wrongful termination and harassment cases, and conservatorship hearings.

- **Insurance Settlements**: Insurance companies rely on psychodiagnostic testing for a variety of disability and Workman's Compensation cases. Similarly, the Department of Social Services routinely uses psychodiagnostic tests to make Social Security determinations. Psychodiagnostic testing is particularly useful in ruling out malingering.

- **Employment Environments**: Psychodiagnostic testing was originally developed during World War II a screening device to increase the efficacy in deploying military personnel in stressful situations. It is still used extensively by police departments, the military, and other employers to ensure that recruits are psychologically suited to the required tasks.

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- **School Settings**: Psychodiagnostic testing is used by counselors in schools and universities to help students make career choices based on their aptitudes and abilities. It is also the mainstay of assessments for special education placement, admission to gifted programs, and learning disability assessment.

PSYCHOTHERAPY

Psychotherapy is the use of psychological methods, particularly when based on regular personal interaction, to help a person change and overcome problems in desired ways. Psychotherapy aims to improve an individual's well-being and mental health, to resolve or mitigate troublesome behaviors, beliefs, compulsions, thoughts, or emotions, and to improve relationships and social skills. Psychotherapy is a form of **treatment** based on the **systematic use of a relationship** between therapist and patient (as distinct from pharmacological or social methods) **to produce change** in feelings, thinking and behaviour. The advantage of this definition is that it highlights how the quality of the interpersonal relationship forms the basis for therapeutic efficacy, whatever techniques are employed to this end. As with all interpersonal relationships, communication is an intrinsic aspect of psychotherapy. The predominant medium of communication involves the use of spoken language. However, non-verbal means (e.g. body sculpting, drama, music, art and play) have been employed for psychotherapeutic purposes as well.

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The Goals of Psychotherapy

In general, the goals of psychotherapy are as follows:

(1) removal of distressing symptoms;
(2) altering disturbed patterns of behaviour;
(3) improved interpersonal relationships;
(4) better coping with stresses of life;
(5) personal growth and maturation.

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Types of Psychotherapy

Psychologists generally draw on one or more theories of psychotherapy. A theory of psychotherapy acts as a roadmap for psychologists: It guides them through the process of understanding clients and their problems and developing solutions.

Approaches to psychotherapy fall into five broad categories:

Psychoanalysis and psychodynamic therapies. This approach focuses on changing problematic behaviors, feelings, and thoughts by discovering their unconscious meanings and motivations. Psychoanalytically oriented therapies are characterized by a close working partnership between therapist and patient. Patients learn about themselves by exploring their interactions in the therapeutic relationship. While psychoanalysis is closely identified with Sigmund Freud, it has been extended and modified since his early formulations.

Behavior therapy. This approach focuses on learning's role in developing both normal and abnormal behaviors.

a) Ivan Pavlov made important contributions to behavior therapy by discovering classical conditioning, or associative learning. Pavlov's famous dogs, for example, began drooling when they heard their dinner bell, because they associated the sound with food.
b) "Desensitizing" is classical conditioning in action: A therapist might help a client with a phobia through repeated exposure to whatever it is that causes anxiety.
c) Another important thinker was E.L. Thorndike, who discovered operant conditioning. This type of learning relies on rewards and punishments to shape people's behavior.
d) Several variations have developed since behavior therapy's emergence in the 1950s. One variation is cognitive-behavioral therapy, which focuses on both thoughts and behaviors.

Cognitive therapy. Cognitive therapy emphasizes what people think rather than what they do.

a) Cognitive therapists believe that it's dysfunctional thinking that leads to dysfunctional emotions or behaviors. By changing their thoughts, people can change how they feel and what they do.
b) Major figures in cognitive therapy include Albert Ellis and Aaron Beck.

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Humanistic therapy. This approach emphasizes people's capacity to make rational choices and develop to their maximum potential. Concern and respect for others are also important themes.

a) Humanistic philosophers like Jean-Paul Sartre, Martin Buber and Søren Kierkegaard influenced this type of therapy.
b) Three types of humanistic therapy are especially influential. Client-centered therapy rejects the idea of therapists as authorities on their clients' inner experiences. Instead, therapists help clients change by emphasizing their concern, care and interest.
c) Gestalt therapy emphasizes what it calls "organismic holism," the importance of being aware of the here and now and accepting responsibility for yourself.
d) Existential therapy focuses on free will, self-determination and the search for meaning.

Integrative or holistic therapy. Many therapists don't tie themselves to any one approach. Instead, they blend elements from different approaches and tailor their treatment according to each client's needs.

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Daily activity report

Day 1

Day 2

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CASE STUDY- II (Claustrophobia)

SOCIO-DEMOGRAPHIC DATA:

Name:	Mr. SK
Age:	55
Marital status:	Married
Gender:	Male
Occupation:	Businessman
Education:	12th pass
Religion:	Hindu
Mother tongue:	Bengali
Location of residence	Kolkata, West Bengal
Socioeconomic status:	Upper
Informant:	Brother
Reliability:	Reliable and consistent

CHIEF COMPLAINTS

According to patient

"whenever I am in crowd or I think about being in crowd then I feel uneasy and get sensation of cold feet and hands. I feel like I will die"

"I have problem to be in closed places like lifts and planes. But I also feel anxious when I am alone at home."

Informant states that

"His condition is causing a lot of distress to his family and they are ready to do anything to get him treated"

HISTORY OF PRESENT ILLNESS

Five years ago the patient had started showing symptoms of anxiety and panic attacks. he would have such attacks when he is in closed space or is alone at home. He would experience racing hearts, cold hands and feet, chest pain, difficulty breathing and palpitation. He thought he had heart problem. As a result, he had many physical examinations like ECG etc. But everything came out normal. He had gone to many doctors for treatment including homeopathy, naturopathy

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etc. Six months back he was alone at home and fainted in bathroom after panic attack as a result general physician advised him to see a psychiatrist.

He has travelled all the way from Kolkata to see a psychiatrist. Since he is afraid of travelling in plane he came by train whereas his brother came by plane. He feels that lift will be closed and he will be stuck in lift. He also experiences anxiety before sleeping and live in fear that he may have attack any time as a result he feels stressed and restless most of the time which is causing a lot of distress to family as well. He is the only breadwinner of the house. he has done treatment from many doctors but nothing helped.

Mode of onset:	insidious
Course of illness:	fluctuating
Progress of illness:	static
Duration of illness:	5 years
Predisposing factors:	Being in closed places or alone at home
limiting factors:	when patient goes to open space, deep breath, rub his hands and drink water
Associated disturbance:	lack of sleep, restlessness and stress
perpetuating factors:	anxiety in psychological factors

PAST PSYCHIATRY AND MEDICAL HISTORY

NIL

TREATMENT HISTORY

Patient is currently not taking any medication. But in the past he had gone to many doctors to treat his physical symptoms but nothing had helped him.

BIOLOGICAL FUNCTIONING

Sleep:	client is not sleeping well from two weeks.
Appetite:	normal
Energy:	Active

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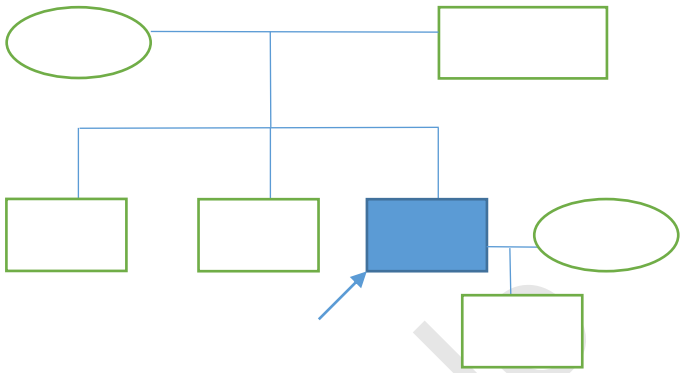
NEGATIVE HISTORY

There is negative history of heart disease, high blood pressure and diabetes

FAMILY HISTORY



There is no consanguinity between parents of the client. The client's mother is a housewife and his father has retired from his business as he is not keeping well. He has two elder brother and they share a good bond. The client has a son who is pursuing his higher education from USA.

PERSONAL HISTORY

Birth and development history: Not available

Behavior during childhood

The client stated that he had always been anxious growing up. He used to worry a lot during exams and would not be able to sleep and eat properly. He used to be introvert child and had trouble talking with strangers. He described himself as a shy person. He didn't have many friends but he shared close bond with few people.

Academic History:

Client is 12th pass. He didn't have much interest in studying as a result he joined his family business after 12th class. He liked playing cricket when he was in school.

Sexual history

Not available

Premorbid personality

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The client is introverted and anxious person. He is spiritual. he has difficulty bonding with people.

MENTAL STATUS EXAMINATION

GENERAL APPEARANCE & BEHAVIOUR:

Appearance is neatly dressed. The client has touch with the surrounding. Gait and gesture is normal. Rapport could be established and has a positive attitude towards examiner.

MOVEMENT AND BEHAVIOUR:

The psychomotor movement is normal.

SPEECH:

Speech is normal. The intensity / Tone is normal and Productivity is also normal. The client's speech is coherent and goal directed. Rate of speed is normal and there is no pressure or poverty of speech is observed.

MOOD / AFFECT:

- **Subjectively:** "I am worried"
- **Objectively:** The client is concerned about his health.

The depth and the intensity of the affect is normal. Mood is observed as congruent to the thought, communicable and appropriate to the situation.

THOUGHT:

- **Content-** the client had preoccupation about fear of closed spaces.

PERCEPTION:

No perceptual disturbances is seen from the client

COGNITIVE FUNCTIONS:

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- The client is oriented to time, place and date
- Attention & Concentration is aroused and sustained
- Memory:

  Immediate memory: intact

  Recent memory: intact

  Remote memory: intact
- Abstraction:

  Similarities: adequate

  Differences: adequate

  Proverb: adequate
- General fund of knowledge: adequate
- Judgment:

  Personal: intact

  Social : intact

  Test: intact

JUDGMENT:

- **Personal:**
- **Social:** } Intact
- **Test:**

INSIGHT:

Level 6- true emotional insight: emotional awareness of the motives and feelings of illness which leads to changes in behavior or lifestyle

DIAGNOSIS

The patient was diagnosed with Claustrophobia F40.2. The patient exhibit symptoms of hot flashes, panic attacks, tension, sweating, nausea and fainting.

TREATMENT PLAN

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The client was prescribed medicine to reduce the symptoms of anxiety. He was advised to start psychotherapy as soon as possible. Doctor advised him to come again after two weeks.

One of the follow up session

SEVEN COLUMN THOUGHT RECORD

Event	Identify your mood (%)	Identify automatic thoughts or images	What Evidence Do You Have To Support This Thought?	What Other Perspective You Can Take On This?	What Evidence Do You Have To Support This Alternative Perspective?	How Much Do You Still Believe Your Initial Thoughts? (%)
Going in lift	90%	I feel that lift will stop and I would faint. I feel like I will die in lift.	Once when I went to mall the lift power went off and lift stopped for 2 minutes	That there could be some technical issues and it rarely happens. Even if it happens that does not mean I will die of suffocation .	I haven't heard anyone dying inside the lift because it was crowded or power went off for few minutes	60 %

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In the first column he was asked to write about the situation which makes him feel anxious. In the second column he was asked to write the negative emotions he was feeling from a scale of 0 to 100. In third column, to identify his automatic negative thoughts and images which comes to his mind when he thinks of using lift. In fourth column, write his real thoughts and evidence which supports his thought. In fifth column client wrote to introspect other perspective followed by evidence which support the new perspective. At the end when client was asked about his feeling he gave score of 60, which is a significant improvement from 90. We ended the session with the client and asked him to come after a week.

FUTURE TREATMENT PLAN

Future treatment plan is to give exposure therapy to client after a couple of sessions. It s a type of behavioral therapy that is designed to help people manage problematic fears. Through the use of various systematic techniques, a person is gradually exposed to the situation that causes them distress. The goal of exposure therapy is to create a safe environment in which a person can reduce anxiety, decrease avoidance of dreaded situations, and improve one's quality of life.

Psychologist is focused to give systematic desensitization technique to client. It is a technique incorporates relaxation training, the development of an anxiety hierarchy, and gradual exposure to the feared item or situation. The relaxation training might include progressive muscle relaxation and guided imagery. The anxiety hierarchy might use something like Wolpe's Subjective Units of Discomfort Scale (SUDS) to create a list of anxiety-producing events on a scale from 0-100. Then, during the gradual exposure to the ranked items, the learned relaxation techniques are applied to offset stress and anxiety.

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CASE STUDY- III (Bipolar affective disorder, hypomanic)

SOCIO-DEMOGRAPHIC DATA:

Name:	Mr. AK
Age:	26
Marital status:	unmarried
Gender:	Male
Occupation:	Student
Education:	BBA
Religion:	Hindu
Mother tongue:	Hindi
Location of residence	Bangalore
Socioeconomic status:	Upper
Informant:	father and uncle
Reliability:	Reliable and consistent but inadequate

CHIEF COMPLAINTS

According to the patient

"I have no problem. My mind is super fast and no one can match it."

According to the informant

"he has become very aggressive and started abusing people. He had fights with his friends and brother. He thinks that he is very intelligent and look down on others."

HISTORY OF PRESENT ILLNESS

The onset of the illness is acute. The client was apparently well a week ago. Three days before he got to know that he cleared his entrance exam in IIM- Ahmedabad. He had been very ecstatic about it. Later in the evening he got aggressive to his younger brother who jokingly said that he may have cheated in entrance exams. He responded him saying that his mind is super fast and he does not cheat like he does.

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Next day while returning back home at bus station station he abused his best friend and asked him to jump off in front of bus. he even tried to push him.

Next day he again abused his friend and got aggressive he kept repeating that no one can match him. His father decided to bring him to the hospital. Currently there is no significant change in his sleep pattern, he can maintain hygiene however his energy level increased his appetite has decreased from past 2 days.

PAST PSYCHIATRY AND MEDICAL HISTORY

The patient does not have any kind of past illness/psychiatric illness Treatment History-

TREATMENT HISTORY

NIL

BIOLOGICAL FUNCTIONING

Sleep: client has not slept from 1 days

Appetite: decreased

Energy: very Active

FAMILY HISTORY

The patient family is a nuclear family. His father is a bank manager and brother is doing his graduation. Family atmosphere is good. The patient financial status is also good.

PERSONAL HISTORY

Birth order: first born, he has one younger brother.

Birth and development history:

-Birth history was normal, Birth cry was present, Birth weight 2 kilo, Developmental milestones achieved before handed, no emotional or physical problems were present in childhood.

Behavior during childhood

The patient was good in school and used to score good marks. He had many friends growing up and is an extrovert.

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Sexual history

Not elicited

Premorbid personality

The patient was extrovert and had many friends, he never showed any kind of resistance earlier or aggressiveness

MENTAL STATUS EXAMINATION

GENERAL APPEARANCE & BEHAVIOUR:

He was good wearing a check shirt and pant, hair was properly made well dressed and groomed, Behaviour was restless was wringing his hands and the patient was uncooperative, hyperactive, restless but well dressed. Attitude towards examines- uncooperative, Rapport could not be established

MOVEMENT AND BEHAVIOUR:

Agitation was present and the patient was constantly moving his hands.

SPEECH:

Rapid, pressure of speech was observed

productivity–high

Reaction time was decreased

MOOD / AFFECT:

Mood - irritable, euphoric

Affect- broad–congruent with mood

PERCEPTION:

No perceptual disturbances are seen from the client

THOUGHT:

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Content- Ideas of grandiosity, Form- flight of ideas, rapid thinking, tangentially (where the patient does not come to the point)

COGNITIVE FUNCTIONS:

- The client is oriented to time, place and date
- Attention & Concentration is aroused and sustained
- Memory:

  Immediate memory: intact

  Recent memory: intact

  Remote memory: intact
- Abstraction:

  Similarities: adequate

  Differences: adequate

  Proverb: adequate
- General fund of knowledge: adequate

JUDGMENT:

Personal: intact

Social : intact

Test: intact

INSIGHT:

Level 1 - complete denial of the illness

DIAGNOSIS

The patient was diagnosed with bipolar affective disorder, current episode hypomanic. F31.0. The patient exhibited symptoms of increased energy and activity, talkativeness, decreased need for sleep, irritability and currently experiencing hypomanic episode.

TREATMENT PLAN

He was prescribed mood stabilizers. He was asked to come after a week. Based on his condition he will be given various psychosocial treatments such as cognitive behavior therapy, interpersonal therapy etc.

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Following are the treatment plans which are helpful for bipolar patient.

Medication – Medication is the cornerstone of bipolar disorder treatment. Taking a mood stabilizing medication can help minimize the highs and lows of bipolar disorder and keep symptoms under control.

Psychotherapy – Therapy is essential for dealing with bipolar disorder and the problems it has caused. Working with a therapist, patient can learn how to cope with difficult or uncomfortable feelings, manage stress, and regulate mood.

Education – Managing symptoms and preventing complications begins with a thorough knowledge of illness. The more patient and his family know about bipolar disorder, the better they will be able to avoid problems and deal with setbacks.

Lifestyle management – By carefully regulating lifestyle, patient can keep symptoms and mood episodes to a minimum. This involves maintaining a regular sleep schedule, avoiding alcohol and drugs, eating a mood-boosting diet, following a consistent exercise program, minimizing stress, and keeping sunlight exposure stable year-round.

Support – Living with bipolar disorder can be challenging, and having a solid support system in place can make all the difference in outlook and motivation of the patient. The support of friends and family is invaluable.

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CASE STUDY –V (Schizophrenia)

SOCIO-DEMOGRAPHIC DATA:

Name:	Mr S
Age:	36
Marital status:	Married
Gender:	Male
Occupation:	Accountant
Education:	BCOM
Religion:	Christian
Mother tongue:	kannada
Location of residence	Bangalore
Socioeconomic status:	lower
Informant:	father
Reliability:	Reliable and consistent but inadequate

CHIEF COMPLAINTS

According to the patient he had not been feeling well.

According to the informant the patient had been talking to self, increased activity, reduced sleep and reduced appetite. The duration of illness is since one month.

HISTORY OF PRESENT ILLNESS

The patient was well before one month. The time of onset was one month back. The symptoms were talking to self, increased activity, reduced sleep and reduced appetite. No suicidal ideas.

PAST PSYCHIATRY AND MEDICAL HISTORY

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The first episode of illness started when client was 25-year-old. At that time the client ran away from home and after 1 year came back with mental illness. So no history of precipitating factor is available. At that time, he was treated in CADABAM hospital. After that his condition got better and he went back home. 1 year back he again had relapse and had been on medication.

BIOLOGICAL FUNCTIONING

Sleep: Very poor

Appetite: decreased

Sexual interest and activity: Normal

Energy: Active

TREATMENT HISTORY

Client was on treated at CADABAM hospital when he first showed symptoms.

FAMILY HISTORY

Client belongs to a nuclear family. He is married and staying separately with his wife and son. He has 18 months old son. Client is the only son is the family and share good bond with them. His grandfather had some psychotic symptoms but not much information could be elicited.

PERSONAL HISTORY

Birth and Developmental History:

Delivery was normal and client was born in house. No history of birth defects. Development milestones were achieved on time.

Behavior during Childhood:

Client was brought up by his father and mother. Breast feeding was adequate and weaning started on 6th month of age. No history of maternal deprivation. Milestones were normal and had temper tantrum during childhood.

Academic History:

Client's formal education was started at the age of 5 years. He had good relationship with his peer group and teachers during the school life. He had no school phobia.

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PLAY HISTORY

Client was used to play with his friends during the school life. He used to find out pleasure from play during his childhood. He had no close friendship.

OCCUPATIONAL HISTORY

Client worked as a accountant. Now he had no job due to illness. He had no job satisfaction.

SEXUAL AND MARITAL HISTORY

Client is married and consanguine. He had no gender identification disorder. He had no history of sexual relationship with others. He had no psychosexual dysfunction. He had no extra marital sexual relationship.

PREMORBID PERSONALITY:

Client had good relation with family members, workmates, friends and superiors. He is introverted. He had less social interaction. He uses his leisure time watching television. He has good self confidence and self esteem. He never abused drugs or alcohol.

MENTAL STATUS EXAMINATION

GENERAL APPEARANCE & BEHAVIOR:-

General appearance is well dressed. Facial expression was apathetic. mannerism was present. he maintains eye contact. Gait and posture is normal. Hygiene was poor. Attitude towards the examiner was cooperative and attentive.

MOVEMENT AND BEHAVIOR:

Motor disturbance present (stereotype movement, hyperactivity and compulsion).

SPEECH:

Pressure of speech was accelerated. Flight of ideas were present. thought block was absent. monotonous pitch was observed. Speed was increase and reaction time was slow.

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MOOD / AFFECT:

- Subjectively: : " I am happy and joyful"
- Objectively: laughing
- Pleasurable affect: present, Euphoric.

THOUGHT:

Form of thought disorder: absent

Delusion: present

Client says, "I am the CEO of many companies".

PERCEPTION

Hallucination is present. client says he can see and talk with god.

COGNITIVE FUNCTIONS:

- Not oriented to time, place and person.
- Attention & Concentration is aroused and sustained
- Memory:
  - Immediate memory: intact
  - Recent memory: intact
  - Remote memory: intact
- Abstract thinking impaired.
- Intelligence is impaired
- General fund of knowledge: adequate
- Judgment:
  - Personal: impaired
  - Social : impaired
  - Test: impaired

INSIGHT:

Insight absent (Level 1)

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PROVISIONAL DIAGNOSIS

The client is diagnosed with Schizophrenia(F20) as he has symptoms of delusion of grandiosity, fantasy, auditory and visual hallucination, euphoria, poor abstract and Judgement.

TREATMENT PLAN

Client was put on antipsychotic medication – clozapine 25 mg, olazepin 5 m and valproate 200 He was also suggested to admit in rehab centers for 2 months which will help him in recovery.

Following are the beneficial treatments for Schizophrenic patient:

1) **Medications**: - Medications are the cornerstone of schizophrenia treatment, and antipsychotic medications are the most commonly prescribed drugs. They're thought to control symptoms by affecting the brain neurotransmitter dopamine. The goal of treatment with antipsychotic medications is to effectively manage signs and symptoms at the lowest possible dose. The psychiatrist may try different drugs, different doses or combinations over time to achieve the desired result. Other medications also may help, such as antidepressants or anti-anxiety drugs. It can take several weeks to notice an improvement in symptoms.

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2) **Psychosocial interventions: -** Once psychosis recedes, in addition to continuing on medication, psychological and social (psychosocial) interventions are important. These may include:

- **Individual therapy** -Psychotherapy may help to normalize thought patterns. Also, learning to cope with stress and identify early warning signs of relapse can help people with schizophrenia manage their illness**.**

- **Social skills training** - This focuses on improving communication and social interactions and improving the ability to participate in daily activities.

- **Family therapy-** This provides support and education to families dealing with schizophrenia.

- **Vocational rehabilitation and supported employment-** This focuses on helping people with schizophrenia prepare for, find and keep jobs.

3) **Hospitalization:** - During crisis periods or times of severe symptoms, hospitalization may be necessary to ensure safety, proper nutrition, adequate sleep and basic hygiene.

4) **Electroconvulsive therapy:** - For adults with schizophrenia who do not respond to drug therapy, electroconvulsive therapy (ECT) may be considered. ECT may be helpful for someone who also has depression.

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CASE STUDY- VII (Moderate Depressive episode without somatic syndrome)

SOCIO-DEMOGRAPHIC DATA:

Name:	CT
Age:	16
Marital status:	unmarried
Gender:	Male
Occupation:	student
Education:	X std.
Religion:	Hindu
Mother tongue:	Hindi
Location of residence	Bangalore
Socioeconomic status:	Upper
Informant:	Mother
Reliability:	Reliable ,consistent and adequate

CHIEF COMPLAINTS

According to informant

The boy is not interested in anything be his studies or any hobby. He keeps staring at something. He was good in study until 9th Class but slowly became slow and now his performance is very poor academically. He is not doing homework and there are constant complains from school because of his aloofness and loss of interest. He started crying a lot on small things and says that he is not able to study then he gets angry and throw his books. His sleep is disturbed. he wakes up at night feeling scared.

HISTORY OF PRESENT ILLNESS

The client was good in studies until class 9th. But since one year he is not performing well in school and stays aloof. His problem is intensified from last 2 months. He have been feeling hopeless and says that he cant study. He has started crying a lot a trivial things. from last 2 days he is being aggressive and irritated and has not gone to school. He was at his room from last 2 days.

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PAST PSYCHIATRY AND MEDICAL HISTORY

Nil

TREATMENT HISTORY

NIL

BIOLOGICAL FUNCTIONING

Sleep: disturbed

Appetite: decreased

Sexual interest and activity: NA

Energy: low

NEGATIVE HISTORY

No history of head injury, epilepsy, seizures, trauma, and no history of repetitive thoughts and behaviors, firm beliefs, elation of mood or depersonalization or de-realization.

FAMILY HISTORY

There is no consanguinity between parents of the client. The client is the middle child. He as two sisters one elder and one younger. Clients parents are overprotective since he is the only son in the family. 5 years back he got dengue after that his mother is overly protective of him and does not allow him to got out and play.

FAMILY INTERACTION PATTERN:

The communication in the family is seen normal. Mother looked very concern. Decisions in the family is headed by the husband with the consent of everyone in the family. There is good cohesiveness in the family. There is not seen negative expressed emotions from the family towards the client

PERSONAL HISTORY

Birth and development history: normal, no birth disorder.

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Academic History:

The client was good in studies. But before one year he has started loosing interest and get low marks

Occupational History:

No occupational history

Sexual History: NA

PRE MORBID PERSONALITY:

Client was introvert. he was good in studies. He had good friends but recently not going out to meet them. His hobby is painting and drawing .

MENTAL STATUS EXAMINATION

GENERAL APPEARANCE & BEHAVIOR:

General appearance is neatly dressed, normal gait and gesture was present. The client has touch with the surrounding. Lack of eye contact observed. The client was comprehensive to simple rules from the clinician and was cooperative for the session.

MOVEMENT AND BEHAVIOR:

slow psychomotor movement is observed from the client.

SPEECH:

The speech was normal. Intensity and speed of communication of the client was normal. There was no pressure of speech and it was coherent and goal directed.

MOOD / AFFECT:

- **Subjectively:** "I am sad",
- **Objectively:** the client was sad and tearful

THOUGHT:

Content: The patient has preoccupation of illness.

PERCEPTION:

No perceptual disturbances could be elicited from the client.

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COGNITIVE FUNCTIONS:

- The client is oriented to time, place and date
- Attention & Concentration is aroused and sustained
- Memory:

  Immediate memory: intact

  Recent memory: intact

  Remote memory: intact
- Abstraction: intact
- General fund of knowledge: adequate
- Judgment:

  Personal: intact

  Social : intact

  Test: intact

INSIGHT:

The client has insight level of 5 which means client has intellectual insight

DIAGNOSIS

Patient is diagnosed with F32.1 Moderate depressive episode without somatic syndrome. Client exhibited symptoms of hopelessness, sadness, cries a lot, isolation etc.

TREATMENT PLAN

Doctor had prescribed him Antidepressant. He had asked him to come after 1 weeks. Doctor strongly advised to go for counselling. clearly he had symptoms of depression cause of which is unknown.

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CASE STUDY- IX (Obsessive Compulsive Disorder)

SOCIO-DEMOGRAPHIC DATA:

Name:	NM
Age:	53
Marital status:	widow
Gender:	Female
Occupation:	Housewife
Education:	Graduate
Religion:	Hindu
Mother tongue:	Kannada
Location of residence	Bangalore
Socioeconomic status:	Upper
Informant:	Son
Reliability:	Reliable and consistent

CHIEF COMPLAINTS

According to informant

The client was reported to have forgetfulness. She worries a lot and get panic very often. She washes her hands and perform her task very slow. She spends most of the time in kitchen where she would keep washing utensils and cleaning the floor of the kitchen. She also spends a lot of time in bathroom to bath and go toilet. If any guest comes at home she gets panic.

HISTORY OF PRESENT ILLNESS

The client has started to show the symptoms one year ago when she started to forget things. she feels that something is falling (dust) so she washes hands frequently. She has two sons .one of them is living separately with the wife and other one got divorced and living with client. She worries a lot about his second son. She reports that praying helps her a lot and she does not have any thoughts of washing or cleaning at that time. Even though she was not much social but had 2 close friends with whom she used to meet but recently she has lost interest in everything and

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does not want to meet anyone. She has arthritis and she find it difficult to do chores but cannot help. if guests come at home she gets panic.

PAST PSYCHIATRY AND MEDICAL HISTORY

Patient has arthritis and diabetes and no history of medical illness.

TREATMENT HISTORY

She takes medicine for arthritis and diabetes but for stress or anxiety she never took any help.

BIOLOGICAL FUNCTIONING

Sleep: does not sleep well

Appetite: Normal

Sexual interest and activity: NA

Energy: low

NEGATIVE HISTORY

No history of head injury, epilepsy, seizures, trauma, no elation of mood or depersonalization or de-realization.

FAMILY HISTORY

There is no consanguinity between parents of the client. The client's parents have died. The client's younger brother lives in same city. The client has 2 sons. One of them is married and live separately whereas other son is divorced and live with his mother.

FAMILY INTERACTION PATTERN:

The communication in the family is seen normal. There is good cohesiveness in the family. There is seen negative expressed emotions from the family towards the client.

PERSONAL HISTORY

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Birth order: first child

Birth and development history: normal delivery and milestones were achieved on time, no childhood disorder present.

Behavior during childhood

Client shared good bond with her parents. In school she felt isolated and had low self esteem. She had very few friends growing up. She was overweight and felt that she is not as good looking as her cousin. As a result, she had low self confidence. She was good in academic. Her parents encouraged her to focus on household chores than study because it will be useful for him after marriage and not her qualification.

Academic History:

The client was good in academic. However, she never participated in any social activity because she thought she was overweight and people will make fun of her. Her hobbies were reading and writing.

Occupational History:

No occupational history

Sexual History:

She shared good relation with her husband .and never had any romantic relation other than her husband.

PRE MORBID PERSONALITY:

The client is introverted, organized and systematic in nature. She finds it difficult to talk with strangers. Client is very religious and prays 2 to 3 hours in a day.

MENTAL STATUS EXAMINATION

GENERAL APPEARANCE & BEHAVIOR:

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General appearance is neatly dressed, normal gait and gesture was present. Client was overweight. The client has touch with the surrounding. Proper eye contact is maintained. Rapport could be established with the client and there was positive attitude towards the examiner. The client was comprehensive to simple rules from the clinician and was cooperative for the session.

MOVEMENT AND BEHAVIOR:

slow psychomotor movement is observed from the client.

SPEECH:

The speech was normal. Intensity and speed of communication of the client was normal. There was no pressure of speech and it was coherent and goal directed.

MOOD / AFFECT:

- **Subjectively:** "I am anxious",
- **Objectively:** the client is anxious and tired

The depth or intensity of mood is normal. The mood is stable. They are congruent to the thought and communicable and appropriate to the situation

THOUGHT:

Content: The patient has preoccupation of illness.

PERCEPTION:

No perceptual disturbances could be elicited from the client.

COGNITIVE FUNCTIONS:

- The client is oriented to time, place and date
- Attention & Concentration is aroused and sustained
- Memory:

  Immediate memory: intact

  Recent memory: intact

  Remote memory: intact
- Abstraction : intact
- General fund of knowledge: adequate

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- Judgment:

  Personal: intact

  Social : intact

  Test: intact

INSIGHT:

The client has insight level of 6 which means she had true emotional insight.

DIAGNOSIS

Patient exhibited symptoms of OCD (obsessive compulsive disorder) F42. The client washes hands frequently and worry about germs. Because of arthritis she is having difficulty working but still she cant help cleaning because of the fear of germs.

TREATMENT PLAN

The doctor prescribed her Tri-cycle antidepressant. she was advised to do physical activity and relaxation.

Along with medicine she was advised to start counselling session.

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CASE STUDY- X (Severe depressive episode with psychotic symptoms)

SOCIO-DEMOGRAPHIC DATA:

Name:	M
Age:	28
Marital status:	Married
Gender:	Male
Occupation:	software engineer
Education:	Btech
Religion:	Hindu
Mother tongue:	Kannada
Location of residence	Bangalore
Socioeconomic status:	Middle class
Informant:	wife
Reliability:	Reliable and consistent

CHIEF COMPLAINTS

According to client

The client reported that when he is alone he feels that someone is talking to him and scolding him for everything he does. He feels that he has done something very bad and people want to harm him for that.

According to informant

Wife reported that he is not sleeping and eating well. He sits alone in room most of time and talks with himself. The symptoms started 2 months ago when client's father died in an accident. After the accident he didn't talk with anyone for long time and slowly started behaving differently. She mentioned that client has fear that people want to harm him. He is also suspicious of his wife that she is also conspiring with others to harm him. He also feels that other people are talking about him.

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HISTORY OF PRESENT ILLNESS

Patient was very restless and agitated. He was not in position to answer anything. He kept repeating that I want to be normal. Patient was accompanied by his wife. According to wife he became quiet and distant after his father's death. He couldn't sleep well so he took sleeping pills which helped him in getting sleep. Recently before 1 week he stopped going to office and remain in his room for most of the time. From last 2 days he is not sleeping and talking to himself. He suspects that others including his wife trying to harm him because he has done something bad. His wife also mentioned that he has been aggressive towards other and suspect that people are talking about him.

Mode of onset: insidious

Duration of illness: - 2 months

PAST PSYCHIATRY AND MEDICAL HISTORY

Client does not have any prior psychiatric or medical history

TREATMENT HISTORY

The client took sleeping pills for few days.

BIOLOGICAL FUNCTIONING

Sleep: not sleeping from 2 days

Appetite: low

Sexual interest and activity: low

Energy: low

NEGATIVE HISTORY

No history of head injury, epilepsy, seizures.

FAMILY HISTORY

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There is no consanguinity between parents of the client. Patient lives with his mother and wife. He had arranged marriage 2.5 years ago. He does not have any child. He is a software engineer whereas his wife teaches in a school.

PERSONAL HISTORY

Birth order: only child

Birth and development history: normal delivery and milestones were achieved on, time no childhood disorder present.

Behavior

The client has been very introverted since childhood. He didn't have any friends growing up. He talked very less and focused on his studies. He does not share much with anyone and talk very less with his mother and wife. He prefers to go on a solo trip.

Academic History:

The client was very good in academic. He felt anxious when he had to talk or give presentation in front of people. He once fainted in school because he was asked to give speech. He likes to go on solo trip.

Occupational History:

Client has been working as a software engineer in MNC from 6 years.

Sexual History:

Data not available.

PRE MORBID PERSONALITY:

The client was introverted , anxious person.

ALCOHOL AND SUBSTANCE HISTROY

Occasionally consume alcohol

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MENTAL STATUS EXAMINATION

GENERAL APPEARANCE & BEHAVIOR:

General appearance was untidy. He hadn't combed for two days. Today he didn't brush and bath. He was staring at one place and constantly blinking. Client was lean and looked unhealthy. no eye contact maintained. Rapport could not be established with the client and there was rude attitude towards the examiner. Client was not cooperative.

MOVEMENT AND BEHAVIOR:

Slow psychomotor movement was observed from the client. He was staring at one place and movement was slow. But he was blinking constantly.

SPEECH:

Thought block was absent. monotonous pitch was observed. Speed was increase and reaction time was slow.

MOOD / AFFECT:

- Subjectively: : " I am worried about my life"
- Objectively: cautious

THOUGHT:

Form of thought disorder: absent

Delusion: present

Client says, "people are trying to harm me".

PERCEPTION

Hallucination is absent.

COGNITIVE FUNCTIONS:

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- oriented to time, place and person.
- Attention & Concentration around but not sustained
- Memory:

  Immediate memory: intact

  Recent memory: intact

  Remote memory: intact
- Abstract thinking impaired.
- Intelligence is impaired
- General fund of knowledge: adequate

JUDGMENT:

Personal: impaired

Social : impaired

Test: impaired

INSIGHT:

Level 2- slight awareness of being sick and needing help, but denying it at the same time.

DIAGNOSIS

The client is diagnosed with major depressive episode with psychotic symptoms. F32.3.

Because he had symptoms of **depression** (sadness, anger, feeling of sadness and hopelessness. Low on socialization and self care) and **psychosis** –aggression, agitation, restlessness, delusions, social isolation, anxiety, persecutory delusions etc.

TREATMENT PLAN

The psychiatrist prescribed anti-depressant and anti-psychotic medicine and suggested his wife to take him to CADABAM hospital where he may be admitted for few days to bring down his agitation. After that based on his progress medication and psychotherapies will be advised.

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LEARNING OUTCOME

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